Hospital/ESRD Request for Survey

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY
10 West Street, Boston, MA 02111
Tel: 617.753.8000
Fax: 617.753.8095

Prepared by: ______________________ Date: __________

Title: ______________________ Tel.: __________

I. APPLICANT

Licensed Facility: ______________________

CEO: ______________________

Name | Title | Telephone

____

Street | City | State | ZIP

II. PROJECT DESCRIPTION RESPOND FOR *THIS PROJECT* AND *THIS SITE* ONLY

❑ Renovation ❑ Hemodialysis Station(s) added: # ________ ❑ New satellite facility

❑ Transfer of site ❑ New bed(s) added: # ________ ❑ Bed reclassification

❑ New service ❑ Other (describe) ______________________

Facility Name: ______________________
(Unit, Department, etc. NB: For new satellites, enter the d/b/a that will appear on the license and on signage.)

Project Address: ______________________
(Bldg./Floor/Suite)

____
(Street/City/ZIP)

DPH Plan Approval Date: ________________

Projected occupancy date: ________________

Total square footage: ________________

DoN # : ________________

DoN Approval Date: ________________

DoN not applicable: ❑

Brief description of project to be surveyed, below:
(Include services to be provided)

____

____

III. SURVEY CONTACT PERSONNEL RESPOND FOR *THIS PROJECT* AND *THIS SITE* ONLY

Clinical contact:

____

Name | Title | Telephone | FAX | E-Mail

Project contact:

____

Name | Title | Telephone | FAX | E-Mail

IV. DOCUMENTATION respond for *THIS PROJECT* and *THIS SITE* only

IF AN APPROVAL HAS NOT YET BEEN OBTAINED (E.G. APPLICATION FILED, SURVEY SCHEDULED), CHECK "PENDING" AND EXPLAIN THE CURRENT STATUS IN THE "COMMENTS" AT THE BOTTOM OF THIS SECTION. APPEND, AS NEEDED.			ATTACHED ✔	PENDING ✔	DOES NOT APPLY ✔
1. Project narrative: Include the services provided and other information that explains the scope of the project to be surveyed. For multi-phase projects delineate each phase and its projected date for implementation.					
2. Small scale drawing of floor plan					
3. Self-certification architectural checklist					
4. Bed capacity form (if project involves inpatient beds)					
5. Staff schedules for this project					
6. DPH Waivers (response to conditions of waivers, attach addendum)					
7. Massachusetts Department of Public Safety (DPS) Certificate	Expiration date:				
8. Local Fire Department Certificate of Approval	Issue date:				
9. Local Occupancy Certificate of Approval	Issue date:				
ITEMS 10-15: SUBMIT A <u>TEST REPORT</u> *AND* <u>STATEMENT OF COMPLIANCE</u>. THE STATEMENT OF COMPLIANCE IS A WRITTEN VERIFICATION FROM A QUALIFIED PROFESSIONAL THAT THE EQUIPMENT IS INSTALLED AND OPERATING ACCORDING TO STANDARDS *[in italics]*.		STATEMENT DATE ↓			
10. Medical Gas Testing *[AIA Guidelines/NFPA 99]*					
11. Air Balancing (HVAC) *[DPH approved plans]*					
12. Water Testing (for hemodialysis services, to include ICU sites, etc.)	a. Chemical test →				
[Per *Association for the Advancement of Medical Instrumentation*]	b. Biological test →				
13. Emergency Power *[AIA Guidelines/NFPA 99)*					
14. Heat/Humidity Controls *(AIA Guidelines/105CMR 130.624]*					
15. Equipment Preventive Maintenance Data *[per manufacturer]*					

COMMENTS:

V. SPECIALTY CHECKLIST

RESPOND FOR *THIS PROJECT* AND *THIS SITE* ONLY

SPECIALTY AREA	APPROVALS REQUIRED OR ISSUED PLEASE SUBMIT COPIES WHERE APPLICABLE			
1. WILL THE FOLLOWING TECHNOLOGICAL DEVICE SERVICES BE PROVIDED ON SITE?	YES ✔	NO ✔	DETAILS	
Diagnostic X-ray (Includes dental exams, Flouroscopy, cardiac catheterization, etc.)			Registration #	Expiration date
Therapeutic X-ray			Registration #	Expiration date
Mammography			Registration # License #	Expiration date Expiration date
CT Scan			Registration #	
Therapy Simulator			Registration #	Expiration date
Linear Accelerator			Registration #	Expiration date
Bone Densitometer			Registration #	Expiration date
Laser			Approval date	
Nuclear Medicine			License #	Expiration date
RF Diathermy/RF Hyperthermia				

2. ADDRESS THE STATUS OF MAJOR EQUIPMENT FOR THIS PROJECT IN THE NEXT 2 ITEMS.	ATTACHED ✔	PENDING ✔	DOES NOT APPLY ✔	STATEMENT OR APPROVAL DATE ↓
If this project involves the installation of major equipment (e.g. CT Scan, MRI) for any of the services, above, submit a statement that it is assembled/installed/adjusted according to the manufacturer's instructions. (Use Form FDA 2579, if applicable).				
Projects involving radiation shielding design must be approved by ***DPH*** Radiation Control Program.				

	YES ✔	NO ✔	PEN-DING ✔	DETAILS	
3. WILL MENTAL HEALTH SERVICES BE PROVIDED?				Inpatient ❑	Outpatient ❑
Department of Mental Health License: (Locked units, only)				License #	Expiration date
4. WILL SUBSTANCE ABUSE SERVICES BE PROVIDED?				Inpatient ❑	Outpatient ❑

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[V. SPECIALTY CHECKLIST - CONTINUED] RESPOND FOR *THIS PROJECT* AND *THIS SITE* ONLY

SPECIALTY AREA	YES ✔	NO ✔	PEN-DING ✔	DETAILS	
5. WILL PRESCRIPTION MEDICATIONS BE STORED ON SITE?					
DPH, Div. of Food and Drug Registration:				REGISTRATION # EXPIRATION DATE	SCHEDULE(S) (✔) ❑ II ❑ III ❑ IV ❑ V ❑ VI
Federal Drug Enforcement Administration Registration:				REGISTRATION # EXPIRATION DATE	SCHEDULE(S) (✔) ❑ II ❑ III ❑ IV ❑ V
6. WILL A PHARMACY BE PROVIDED ON-SITE?					
MA Board of Pharmacy Registration:				REGISTRATION #	EXPIRATION DATE
7. WILL LABORATORY (TESTING) SERVICES BE PROVIDED? LABORATORY TEST INCLUDES ALL TYPES OF TESTING (E.G., DIPSTICK, TABLET, POINT-OF-CARE, MODERATE/HIGH COMPLEXITY, CULTURES) PERFORMED ON ANY BODY FLUID (E.G. BLOOD, SERUM, URINE, FECES).					
CLIA Certificate of Approval:				CERTIFICATION #	CERTIFICATION DATE
State Licensure Approval:				APPROVAL DATE	
8. WILL TRANSFUSION SERVICES BE PROVIDED?					
9. WILL BLOOD BANK SERVICES BE PROVIDED?				APPROVED BY ❑ AMERICAN ASSOCIATION OF BLOOD BANKS ❑ COLLEGE OF AMERICAN PATHOLOGISTS	

COMMENTS:

[DPH use only]
Reviewed by: ______________________ Date: ____________ Approval date: ______________
Comments: